

Prior Authorization Model of Repetitive Scheduled Non-Emergent Ambulance Transports

Frequently Asked Questions

1. What states does this model impact?

This prior authorization model initially began in 2014 in the states of New Jersey, Pennsylvania, and South Carolina based on where the ambulance is garaged.

The model was expanded on January 1, 2016 to Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia based on where the ambulance is garaged.

2. Why did CMS choose these states?

New Jersey, Pennsylvania, and South Carolina were selected for initial implementation of this process because of their high utilization and improper payment rates. The June 2013 Medicare Payment Advisory Commission's (MedPAC) Report to Congress: "Medicare and the Health Care Delivery System" found that six states had higher than average spending on non-emergent ambulance transport per dialysis beneficiary than other states. When these six states were ranked by total Medicare expenditures on non-emergent ambulance services, New Jersey, Pennsylvania, and South Carolina were in the top three.

The model was expanded to Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia in accordance with Section 515 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

3. When are the effective dates of the prior authorization of repetitive scheduled non-emergent ambulance model?

The model began in South Carolina, New Jersey and Pennsylvania on December 1, 2014 for transports occurring on or after December 15, 2014. All repetitive scheduled non-emergent ambulance transports in these states with a date of service on or after December 15, 2014 must have completed the prior authorization process or the claims will be stopped for pre-payment review.

The model began in Delaware, the District of Columbia, Maryland, North Carolina, Virginia and West Virginia on December 15, 2015 for transports occurring on or after January 1, 2016. All repetitive scheduled non-emergent ambulance transports in these areas with a date of service on or after January 1, 2016 must have completed the prior authorization process or the claims will be stopped for pre-payment review.

4. What is prior authorization?

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before the service is furnished to a beneficiary and before a claim is submitted for payment. Prior authorization helps to make sure that applicable

coverage, payment, and coding rules are met before services are rendered while ensuring access to and quality of care. Some insurance companies, such as TRICARE, certain Medicaid programs, and the private sector, use prior authorization processes to help ensure proper payment before the service is rendered.

5. What does the prior authorization model do?

The model establishes a prior authorization process for repetitive scheduled non-emergent ambulance transport to reduce utilization of services that do not comply with Medicare policy while maintaining or improving quality of care.

6. Are hospital-based ambulance providers included in this model?

No, hospital-based ambulance providers which are owned and/or operated by a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program are not included in this model and should not request prior authorization.

7. Are independent ambulance suppliers included in this model?

Yes, independent ambulance suppliers are included in this model.

8. What is the definition of repetitive ambulance transport?

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished 3 or more times during a 10-day period; or at least once per week for at least 3 weeks. Repetitive ambulance services are often needed by beneficiaries receiving dialysis or cancer treatment.

9. What does the ambulance Medicare benefit cover?

Medicare covers ambulance services only when medically necessary, which means using other types of transportation could endanger a person's health. To satisfy the medical necessity requirement, the person's condition must require both the ambulance transport and the level of service provided. In addition, the reason for the transport must be to get a Medicare-covered service or return from a covered service. If all requirements aren't met, the person may be billed for ambulance services even if there isn't a signed advance beneficiary notice of noncoverage (ABN). Whether or not a person has a physician's order for an ambulance transport doesn't necessarily prove, or disprove, that the transport was medically necessary. For Medicare to pay for the services the ambulance must meet all Medicare coverage criteria at 42 C.F.R. §§ 410.40, 410.41; Pub. 100-02, *Medicare Benefit Policy Manual*, Ch. 10, §10.2.1.

10. Does prior authorization create new documentation requirements?

Prior authorization does not create new documentation requirements. Prior authorization requires submission of currently mandated documentation earlier in the claims payment process.

11. Is prior authorization required for the repetitive scheduled non-emergent ambulance transport?

Prior authorization for repetitive scheduled non-emergent ambulance transport is voluntary; however, if the ambulance supplier elects not to submit a prior authorization request before the fourth round trip in a 30-day period, the claim related to the repetitive scheduled non-emergent ambulance transport will be subject to a pre-payment medical review.

12. Under prior authorization, how long will Medicare have to provisionally affirm or non-affirm a prior authorization request?

Medicare, through the Medicare Administrative Contractors, will make every effort to postmark a decision on a prior authorization request within 10 business days for an initial request and 20 business days for a resubmitted request.

13. What is a resubmitted request?

A resubmitted request is a request resubmitted with additional documentation after the initial prior authorization request was non-affirmed.

14. In what cases could an ambulance supplier or beneficiary request an expedited review?

An ambulance supplier or beneficiary may request an expedited review when the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. Medicare Administrative Contractors will make reasonable efforts to communicate a decision within 2 business days of receipt of all applicable Medicare required documentation. As these models are for non-emergent services, CMS expects requests for expedited reviews to be extremely rare.

Requests for expedited reviews should be indicated on the prior authorization request package. A reason for the expedited review should also be included.

15. Will there be a tracking number for each prior authorization decision?

Yes, Medicare Administrative Contractors will list the prior authorization tracking number on the decision notice. This tracking number must be submitted on the claim.

16. Where on the claim should the unique tracking number be populated?

When submitting an electronic 837 professional claim for a prior authorized service, the unique tracking number (UTN) must be submitted in the 2300 Claim Information loop in the Prior Authorization reference (REF) segment where REF01 = "G1" qualifier and REF02 =

UTN. A UTN submitted in this loop applies to the entire claim unless it is overridden in the REF segment in the 2400 Service Line loop. This is in accordance with the requirements of the ASC X12 837 Technical Report 3 (TR3).

When submitting a paper CMS 1500 Claim form for a prior authorized service, the UTN must populate the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15.

17. How long can the unique tracking number be used?

A unique tracking number is only valid for the affirmed number of trips during the affirmed time period indicated on the decision letter. Claims submitted with an invalid tracking number will be denied. If additional trips are needed, a new prior authorization request may be submitted to obtain a new unique tracking number. Claims may also be submitted without a unique tracking number; however they will be stopped for prepayment review.

18. Will these claims still be subject to additional post-payment reviews?

Generally, the claims that have a provisional affirmative prior authorization decision will not be subject to additional review. However, CMS contractors, including Zone Program Integrity Contractors and Medicare Administrative Contractors, may conduct targeted pre- and post-payment reviews to ensure that claims are accompanied by documentation not required during the prior authorization process. In addition, the Comprehensive Error Rate Testing contractor must review a random sample of claims for post-payment review.

19. Are facilities responsible for submitting prior authorization requests?

No, the ambulance supplier or beneficiary is responsible for submitting the prior authorization requests.

20. Is prior authorization needed for beneficiaries during a covered Medicare Part A stay?

If the ambulance transport is included in the bundled Part A payment and is not billed separately to Medicare by the ambulance supplier, prior authorization is not necessary.

21. Are transports of beneficiaries in a skilled nursing facility (SNF) subject to prior authorization?

Transports of beneficiaries in a SNF are subject to prior authorization if the ambulance transport is not included in the bundled SNF payment and an independent ambulance supplier is providing the transport.

22. If the beneficiary's level of service changes from BLS to ALS, for example, would a new prior authorization be required?

Yes, a new prior authorization would need to be submitted.

23. How will CMS administer prior authorization? Is there specialized staff devoted to the program?

The prior authorization is administered by the Medicare Administrative Contractors, the same contractors that currently process claims and conduct medical review on part B services. Clinical staff are assigned to medical review and trained to provide consistency. In addition, we will employ private sector standards in our prior authorization program such as responding to prior authorization requesters within 10 days of receipt of an initial prior authorization package, providing responses that are specific about missing information and giving ambulance suppliers an opportunity to resubmit the prior authorization package for re-review. The contractor has 20 business days to review a resubmission.

24. Will prior authorization allow for electronic submission of prior authorization requests?

Yes. Submitters who choose to utilize the prior authorization process may send prior authorization requests to the Medicare Administrative Contractors via mail, fax, or through the Electronic Submission of Medical Documentation (esMD) system. More information can be found at <http://www.cms.gov/esMD>.

25. When will CMS provide operational details related to prior authorization?

An operational guide with additional details is available on our website at <http://go.cms.gov/PAAmbulance>.

26. Why did CMS choose to test this model on repetitive scheduled non-emergent ambulance transport?

According to the Government Accountability Office “Cost and Medicare Margins Varied Widely; Transports of Beneficiaries Have Increased” the number of Basic Life Support non-emergent transports for Medicare fee-for-service beneficiaries increased by 59 percent from 2004 to 2010.

The Department of Health and Human Services Office of Inspector General (OIG) has published numerous reports about Medicare’s ambulance benefit and has concluded that this benefit is highly vulnerable to abuse. A 2006 OIG study, “Medicare Payment for Ambulance Transport” evaluated the appropriate use of the ambulance benefit and the findings indicated a 20 percent nationwide improper payment rate for non-emergent ambulance transport, meaning 20 percent of non-emergent transports did not meet Medicare’s coverage requirements. The report recommended that CMS implement activities to reduce these improper payments.

In addition, in June 2013, MedPAC published a report that included an analysis of non-emergent ambulance transports to dialysis facilities. Transports to and from dialysis facilities have grown noticeably in recent years and represent a large share of non-emergent ambulance claims. In the 5-year period between 2007 and 2011, the volume of transports to and from a dialysis facility increased 20 percent, more than twice the rate of all other

ambulance transports combined. In 2011, ambulance transports to and from dialysis facilities accounted for nearly \$700 million in Medicare spending, or approximately 13 percent of Medicare expenditures on ambulance services.

27. How many trips are allowed without prior authorization before the pre-payment review begins?

If a prior authorization has not been requested before the fourth round trip in a 30-day period, claims will be subject to pre-payment medical review. CMS will monitor utilization patterns to ensure that suppliers of ambulance services are not routinely limiting needed services to a certain number of trips in order to avoid the prior authorization process.

28. How many ambulance suppliers can request prior authorization for one beneficiary for one time period?

Under this model, CMS allows one ambulance supplier to request prior authorization per beneficiary per time period. If the initial supplier cannot complete the total number of prior authorized transports (e.g., initial ambulance company closes or no longer services that area), the initial supplier's request is cancelled. In this situation, a subsequent ambulance supplier may submit a prior authorization request to provide transport for the same beneficiary and must include the required documentation in the submission.

If multiple ambulance suppliers are providing transports to the beneficiary during the same or overlapping time period, the prior authorization request will only cover the supplier for whom the request was made. Any supplier submitting claims for which no prior authorization request is recorded will be subject to 100 percent medical review.

29. How many trips at a time will be allowed under prior authorization?

A provisional affirmative prior authorization decision will affirm a specified number of trips within a specific amount of time. The prior authorization decision, justified by the beneficiary's condition, may affirm up to 40 round trips (which equates to 80 one-way trips) per prior authorization request in a 60-day period. A provisional affirmative prior authorization decision may affirm a specified number of trips within a specific amount of time and can be for all or part of the requested number of trips. Transports exceeding 40 round trips (or 80 one-way trips) in a 60-day period require an additional prior authorization request.

30. Should a physician attestation of medical necessity be included in the prior authorization request package?

A physician attestation is not required. If the physician attestation meets the criteria for the physician certification statement (PCS), it can be submitted in place of the PCS. However, it would only be valid for 60 days from the date of the physician's signature. Submitting only an attestation statement in addition to the PCS does not establish medical necessity; medical documentation must be attached that supports the PCS and/or physician attestation. The medical documentation must describe the beneficiary's condition(s) that necessitate(s) the type and level of ambulance transports.

31. Are ambulance suppliers under review by a Zone Program Integrity Contractor (ZPIC) eligible to submit prior authorization requests?

No, ambulance suppliers under review by a ZPIC are not eligible to submit prior authorization requests.

32. Where can I send additional questions?

Additional questions on the prior authorization model can be sent to CMS at AmbulancePA@cms.hhs.gov.

33. What should ambulance suppliers do if the certifying physician will not provide the additional documentation?

CMS created an informational letter directed towards physicians that is available for download on the ambulance prior authorization website. Ambulance suppliers can give the letter to certifying physicians reminding them of their responsibility to provide the medical record documentation that supports the Physician Certification Statement.

If the physician and/or facility will still not provide the documentation, ambulance suppliers should notify their Medicare Administrative Contractor or CMS (at AmbulancePA@cms.hhs.gov) of the uncooperative physicians and/or facilities. Physicians and/or facilities who show patterns of non-compliance with this requirement, including those physicians and/or facilities whose records are inadequate or incomplete, may be subject to increased reviews, such as through provider-specific probe reviews.